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ABSTRACT

Intended for school psychclcgists, the paper discusses current approaches to instrumentation in the standardized psychological schools. A framework is presented for the classification of assessment instruments, and examples of some currently employed instruments are provided along with a comparative analysis. Problems identified with existing approaches to standardized instrumentation are reviewed and some new developments in the field presented. (Author/DLS)

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Psychological assessment of severely/profoundly handicapped children in the public schools.

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The Guidelines for implementation of Public Law 94-142, the Education of all Handicapped Act, pose a serious challenge for school psychology. For the first time, teachers of handicapped children are held legally accountable for changes in the educational status of their students. The search within the field of Special Education for standardized instrumentation with which to evidence learning changes is greatly intensifying. School psychologists are increasingly sought to provide this instrumentation. The role of the school psychologist in Special Education is shifting, as a consequence, from screening, diagnosis and placement, to a nearly equal thrust in the area of assessment of educational progress and consultation in curriculum development.

This shift in utilization of the school psychologist is occuring across all areas of Special Education, but is particularly significant in the case of rapidly expanding public school services to the severely/profoundly handicapped. P.L. 94-142 and ensuing implementation legislation at the state level has resulted in a major acceleration in the past two years of "deinstitutionalization" programs. Children who very recently were thought to be strictly the recipients of service under a Public Health delivery system are now the recipients of a full, 6 hour per day public

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education by legal mandate. Long range plans for decreasing the population of state institutions for the retarded in favor of community-based, day care programs, funded largely by the Developmental Disabilities Act have been underway for some time, but are now undergoing a very rapid reorganization. The result of these changes in legislative thrust has been the appearance in public school programs of children whose level of severity of handicap has caused them not to have been previously seen by educational personnel. They are a new phenomenon for all but a few of the nations' school administrators, teachers, social workers, nurses and pscyhologists. They present new challenges across the board: transportation; feeding; classroom equipment and staffing; personnel competencies; curriculum development; instructional design; assesment and tracking of progress.

The intrusion into the already overloaded, understaffed system has seemingly happened "overnight." The search for relevant systems to match the strains on service delivery is on in every facit of the special education apparatus. The school psychologist confronted with the first SMH (severely, multiply handicapped) child to be brought to school searches for the appropriate instruments and techniques to provide an appropriate screening and program referral. The discovery is soon made that no standardized intelligence test will provide any useful information. The child is apt to be in a wheelchair, tied in and propped up with velcro and cushions; in diapers in some cases, and grossly disfigured in others. The child may evidence no functional vision or hearing and be able to use only limited muscles with no motor control over the extremeties. Obviously, there is no doubt that the child is profoundly retarded. Or is there? Many severely handicapped children and young adults coming out of regressive

institutional environments are being found, in the more intensive classroom environment, to possess very extensive receptive language repetoires, and hence a surprising degree of verbal intelligence. The potential for misplacement is high for children of this type.

The next problem to confront the school psychologist, following screening and referral, is assessment (diagnosis) and program planning, as part of the IEP (Individual Educational Plan) team. Again, given a child who does not respond to standardized I.Q. test materials, how may a detailed workup on intellectual functioning be provided which will assist in the formulation of a "prescriptive" program plan for the child's education?

The purpose of this brief paper is to acquaint school psychologists with some contemporary and useful assessment procedures, applicable to educational program planning for severely and profoundly handicapped students in the public schools.

Public schools are rapidly expanding existing programs and developing new programs to meet the needs of this formerly hospitalized and homebound population. Precisely who are the "severely and profoundly handicapped"? That is the subject of yet another more extensive paper (Sontag, Smith & Sailor, 1977); but suffice here to say the term is concerned with students who are profoundly retarded and often multiply handicapped. The rapid appearance of these students in Public School programs has led to severe pressures on both professional and administrative personnel charged with special educational services. Professionals with correct paper qualifications often lack actual experience with students of this type and thus fail to meet the expectations of professionals from other disciplines who have had more experience with the severe and profound. As a result, aspersions are cast and whole professional disciplines are indicted as "useless" and irrelevant.

In California, for example, teacher training institutions have for years prepared teachers with the credential called "severely handicapped." These teachers, however, have been trained and credentialed to educate moderately retarded youngsters typical of the "trainable mentally retarded" (TMR) category. As a result, when placed in charge of classes which consist of the vastly more impaired group, the teachers have often failed to design adequate educational plans and have come up short in relation to their more experienced peers. In many cases, teacher-aides with extensive hospital experience with these students were placed with inexperienced and ill-prepared teachers. The result has been many instances of professional jealousy and a poorly coordinated service to the students.

Of all of the professional persons who provide special services to the public schools, the one who is currently most maligned with respect to the severe/profound classes is the school psychologist. Teachers and teacher aides complain that the psychologist provides no useful information to assist in the development of the IEP (Individual Educational Plan) for each child. It seems, these teachers say, that the psychologist either attempts, with various irrelevant tests, to extract an I.Q. from an untestable child; or launches into a full scale behavior modification attack on the little bit of behavior that the child has, when he/she arrives at school.

The fact is, colleges and universities preparing school psychologists have failed to keep pace with new developments in School District services, just as have teacher training institutions. "Diagnostic" (to use a, hopefully by now, outdated medical term) tools of pragmatic applicability to the severe and profound population have not been placed in the hands of school psychologists. Teachers, teacher aides, speech therapists, physical or

occupational therapists and parents badly need functional service from the school psychologist as a part of the program planning team for the severe/profound student. Educational assessment of the student falls within the scope of activities delivered by this profession. Testing of the student is necessary to determine his/her most appropriate program and to assist the teaching staff in the development of appropriate educational goals and instructional objectives for each student. I.Q. tests are useless and irrelevant for the population and will supply no helpful information.

Sailor & Horner (1976) presented a comprehensive review of educational assessment strategies for the severe/profound as of January 1975. This Chapter also provided an analysis of the theoretical positions underlying the development of assessment systems for this population.

DuBose (1978) has recently updated the review of extant and emerging systems and has provided a very useful table of information on specific checklists which are commercially available. Similarly, Turner & Somerton-Fair (1978) and the Kansas State Department of Education (1978) have provided annotated lists of available assessment systems for the severely handicapped student.

Two new assessment checklists which show a great deal of promise but which are too recent to appear in any classification system are the Range of Motion Evaluation Checklist (Foster & Barnes, 1978) and the Sequential Assessment and Teaching Guide for Severely/Profoundly Handicapped (Falvey & Greenburger, 1978).

Taken altogether, these resources will equip the school psychologist with an invaluable resource library for the selection of appropriate testing technology applicable to the severe and profound.

As DuBose (1978) points out, the newer systems of assessment are tending to be empirically based and derived from studies of the skills

necessary for a student to adapt to community living, whereas the older systems, such as the AAMD Adaptive Behavior Scales (Nihira, Foster, Shellhaas & Leland, 1969) were based largely upon an analysis of skills needed to survive in an institutional setting. In all cases of assessment of the severely handicapped, the emphasis is upon standardized measurement, either criterion-referenced or norm-referenced, which provides descriptive information on specific skills and observable behavior, rather than upon global scores reflecting I.Q., mental age, etc. These latter concepts become meaningless when we are confronted with an 18 year old who cannot pass (or even attempt) the lowest subtest of the WISC. Teachers and support educational staff need as much information as they can get on a wide spectrum of the students' existing skill levels across self-help skills such as dressing or eating; motor skills, such as ambulation; social skills; communication skill development, and so on. The basic question being posed in assessment of the severe/profound is, "What are the students' current skills in independent functioning?" If we can determine precisely what the student can do now, we have models to guide us in determining what he/she needs to learn to do next. The value of a good assessment tool is in its ability to provide a meaningful sample of what the child can presently do.

The first level of assessment is providing an identification and screening function. Despite their low incidence in the total population, severely multiply handicapped children are often more easily initially identified than children with milder handicaps. The seriousness of their deficits is generally apparent to the parents, close family associates and the physician prior to school age or soon after a physical trauma. These children are frequently known, at an early age, to the Department of Health

and other community agencies such as the United Cerebral Palsy Association, the Epilepsy Foundation, the Association for Retarded Citizens and the American Federation for the Blind, In addition, severely multiply handicapped children are identified through a state childfind activity.

Under the best conditions, a newborn infant who is determined before birth on the basis of genetic history, socioeconomic background and other factors to be an extremely high-risk candidate for abnormal development, undergoes a routine Apgar screening and is referred to a pediatric neurologist for a Brazelton assessment if appropriate. The Brazelton (1973) results may suggest referral to an atypical infant program for the prevention of the development of severely multiply handicapped conditions.

The initial screening of a child, whether being newly introduced to the school program or a potential referral from another class, is usually made prior to the determination of the child's service needs and after a comprehensive psychological evaluation to thoroughly assess his or her educational needs.

Detecting a severely multiply handicapped student in the school presents relatively few problems to the psychologist. However, problems may be encountered when a child who has been placed in a moderate mentally retarded class, for example, or in a class of seriously emotionally disturbed, seems unable to achieve.

Resultant referral from one educational program to a class for the severely multiply handicapped must always be based on assessment of the child's service needs. If he or she is found to be primarily in need of basic skill development, referral to the severely multiply handicapped program is appropriate. Referral of a child, e.g., the moderately mentally

retarded, to the severely multiply handicapped program because of a severe behavior disorder is inappropriate if the need is primarily academic. The severely multiply handicapped class must not be allowed to become the "dumping ground" for the difficult-to-handle children in other disability program areas. Such referrals both deny the child the service most appropriate and adversely affect the program for those students for whom the service is appropriate.

Does the child need basic self-help skills such as toilet training, basic motor development programs, basic cognitive or preacademic training, basic communication skills or social skill development? A yes to most of all of the above questions suggests referral to the severely multiply handicapped program. A yes to only one or two of the above probably suggests that the child would be better placed in an academic service program tailored to his or her primary disability, but with aid in specific remedial programs from the staff of the severely multiply handicapped program.

There are no standardized tests or checklists which will, in a single administration, produce educational objectives and a program plan for a child of this disability group. An intelligence quotient or any other single standardized tests score is not an appropriate criterion upon which evaluation can be made.

An analysis of several assessment systems for use with severely multiply handicapped children shows that they fall into three positions on a continuum of comprehensiveness.

Position I: Instruments for screening purpose or for starting programming for a child or class when time is short

Examples: TARC Assessment System
Portage Guide to Early Education

Position II: Instruments to conduct assessment and to formulate an individual educational plan

Examples: Pennsylvania Training Model
Learning Accomplishment Profile

Position III: Instruments which are comprehensive guides to the formulation of instructional objectives

Examples: Balthazar Scales of Adaptive Behavior
AAMD Adaptive Behavior Scales
Behavioral Characteristics Progression

To give an idea of the range of comprehensiveness represented by each position of this classification, and to give a flavor of the type of test items represented, a sample is provided from a comparable skill assessment from each of three instruments: the TARC Assessment System (Sailor & Mix, 1975); the Pennsylvania Training Model Assessment System (Somerton & Turner, 1975); and the Behavioral Characteristics Progression (1973). The skill selected for comparability is the washing (grooming) scale from each system.

Position I: Screening Instruments
TARC Assessment System

WASHING
A. Current performance level (score one)
1. Resists washing.
2. Washes when put through motions only.
3. Washes when accompanied and with help.
4. Washes when suggested, by self.
5. Washes on own initiative, by self, with reminder.

Position II: Assessment and Instructional Objectives
Pennsylvania Training Model

WASHING AND BATHING
1. Child remains in bathtub for an extended period of time.
2. Child plays in bathroom sink by keeping hands under running faucet.
3. Child attempts to wash self with a washcloth.
4. Child tries to apply soap to the washcloth.
5. Child washes all parts of his body except face.
6. Child dries self with assistance.
7. Child helps adult wash and dry his face.
8. Child washes and dries hands and face independently.

46.0 Maintains clean, filed, cut fingernails
47.0 Uses a deodorant when necessary or at regular times
48.0 Cleans glasses, comb, brush when necessary
49.0 Shaves self when necessary or at regular times
50.0 Cares for personal hygiene needs during menstrual cycle - women; Changes pads and pants when necessary. Disposes of soiled pad in designated spot, flushes toilet, washes and dries hands, washes or places soiled clothing in wash.

Each of these systems has a particular approach to observation, recording and scoring which we need not go into here. Also, each system has a particular theoretical model for sequencing which is also a complex issue in itself. The examples given apart from considerations of sequencing and measurement technique convey a flavor of the range and scope represented by all extant systems characteristic of each of the three positions on the classification scheme.

This paper has attempted to provide the school psychologist serving programs for severely/profoundly, multihandicapped students with a resource to the study and selection of relevant, contemporary (diagnostic) assessment techniques for use with this population. It has attempted to convey very briefly some of the issues of concern in testing with this population and, finally, has argued for upgrading the skills of school psychologists to equip them to provide a very needed and necessary support role to the educational staff of these programs.

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